SECTION 8 – EXPENDITURE CLAIMS AND PROPERTY MANAGEMENT

General Information About CMS Quarterly Administrative Expenditure Invoices

I. The quarterly administrative expenditure invoice forms contain the same five line items used in the budgets.

II. Counties/cities are **not** required to submit expenditure justification worksheets with quarterly administrative invoices. However, justification worksheets and/or documentation of how expenditure amounts were derived must be maintained at the county/city level for audit purposes.

III. Quarterly expenditure invoices for salaries and wages must be supported by time studies or attendance documentation maintained at the county/city level for audit purposes. Documentation for staff who qualify for enhanced federal funding and/or who work on more than one program must include quarterly time studies at a minimum, prepared for each budgeted position using the same representative month each quarter. (See page 9-4 and 9-5).

IV. Tools for using time study information to allocate personnel services and benefits expenses are included in References, Section 11.

V. Overhead costs submitted on the quarterly invoices must be consistent with the county/city cost allocation plans for the approved invoicing period. Internal overhead costs must be prepared in accordance with the Office of the Assistant Secretary, Comptroller (OASC) 10 federal guidelines. External overhead costs invoiced for reimbursement must be based on the plan approved by the State Controller's Office (A-87 approval letter). Documentation must be maintained by the county/city for audit purposes.

VI. Invoices must list **actual** expenditures made during the quarter for items approved n the budget justification worksheet, with the following exceptions:

A. Indirect costs are approved estimates for invoicing purposes based on federal OASC-10 cost allocation methods.

B. Staff benefits may be invoiced at an estimated rate for three quarters but must be adjusted to actual costs on the fourth quarter invoice.

C. Counties may not invoice for goods (e.g., equipment, printing, videos, etc.) until after they have actually been received. Budgeted goods that are supported by a purchase order, issued in the budget and for which funds are encumbered may not be received until the following fiscal year. These costs may be included on the fourth quarter invoice or submitted on a supplemental invoice for the fiscal year in which they were encumbered.

VII. For questions concerning the appropriate line item usage for an expense, refer to Section 6 for the definitions of the five line item categories listed on the quarterly invoice or contact the regional administrative consultant/analyst.

VIII. Round all figures to the nearest whole dollar; 50 cents or more is rounded up, and 49 cents and less is rounded down.

IX. Quarterly invoices for expenditures authorized in CMS budgets shall be submitted no later than 60 days after the end of each quarter.

A. First Quarter invoice (time period of July 1 through September 30) is due by November 30.

B. Second Quarter invoice (time period of October 1 through December 31) is due by February 28.

C. Third Quarter invoice (time period of January 1 through March 31) is due by May 31.

D. Fourth Quarter invoice (time period of April 1 through June 30) is due by August 31.

E. Supplemental invoices will only be accepted up to 6 months after the close of the fiscal year for which they apply. The fiscal year ends June 30; therefore December 31 would be the last day to submit supplemental invoices for any given fiscal year.

X. Headings on invoices must contain the identification items identified below. Additional information as identified in the specific and separate CCS or CHDP instructions must also be provided:

A. Program name (i.e., CCS, CHDP)

B. Name of county or city

C. Fiscal year of invoicing period

D. Quarter ending date

- Quarter 1 ends September 30;
- Quarter 2 ends December 31;
- Quarter 3 ends March 31; and
- Quarter 4 ends June 30.

XI. **Signature/Certification blocks** must contain at a minimum the following, with additional information as identified in the specific and separate CCS or CHDP instructions:

A. Contact person name and telephone number

B. Signatures of authorized officials certifying the accuracy of the expenditures reported.

C. Date signed.

NOTE: Invoices submitted without signatures will be returned for authorized signatures before being processed for payment.

XII. Invoices that exceed budgeted funding sources or do not compute will be returned for corrections.

CHDP Quarterly Administrative Expenditure Invoice Instructions

The CHDP Quarterly Administrative Expenditure Invoice (No County/City Match) form is on Page 8-10. The CHDP Quarterly Administrative Expenditure invoice (County/City Match) form is on Page 8-11. All invoices must be prepared in accordance with these instructions in order to receive reimbursement for county/city administrative expenditures.

I. Instructions for Preparation of CHDP Quarterly Administrative Expenditure Invoices (No County/City Match)

CHPD administrative expenditures are reimbursed according to the individual county/city percentages of the Medi-Cal and non-Medi-Cal portions of the approved program's budget.

An exception to application of the non Medi-Cal percentage is for an expenses qualifying as 100 percent Medi-Cal funded, i.e., costs of services exclusively for Medi-Cal eligibles. A county/city program having a category or line item that includes expenses designated as 100 percent Medi-Cal must asterisk (*) the category, footnote the specific amount and have supporting documentation on file. All other expenses have the non-Medi-Cal percentage rate of the individual county/city approved budget applied to distribute the Medi-Cal and non Medi-Cal share of the expenses.

Column 1 will always be the sum of Column 2 and Column 3 for each category/line item. Column 3 will always be the sum of Column 4 and Column 5 for each applicable category/line item.

A. Category/Line Item

1. (I.) Total Personnel Expenses

Enter the total amount for "Personnel Expenses" for the quarter being claimed on this line in Column 1. This amount is the total amount for all employees performing activities for the program as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

Enter the total of non Medi-Cal personnel services claimed in Column 2. This number is derived by multiplying the total expenditures for personnel services in Column 1 by the percentage of the non Medi-Cal share on the approved budget.

Enter the total amount of personnel services expenditures claimed for reimbursement from Medi-Cal in Column 3. This number is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for personnel expenses.

Enter the total amount of Medi-Cal Personnel services claimed for enhanced funds in Column 4 and the total amount claimed for non enhanced funds in Column 5. These amounts are calculated using time study percentages and other applicable documentation.

2. (II) Total Operating Expenses

Enter in Column 1 on this line, the total of all operating expenses.

Enter the non Medi-Cal amount claimed of operating expenses in Column 2. This amount is derived by multiplying the Total Operating Expenses in Column 1 by the percentage of the non Medi-Cal share of the approved budget.

Enter the Medi-Cal amount for operating expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for operating expenses.

Enter the total amount of enhanced operating expenses claimed in Column 4 and enter the nonenhanced operating expenses claimed in Column 5.

NOTE: Only travel and training expenses may qualify as operating expenses in the enhanced funding category, and only when claimed for Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. (III) Total Capital Expenses

Enter in Column 1, the total of all capital expenses. The definitions of equipment and prerequisites for reimbursement are found on Page 8-35.

Enter in Column 2, the amount of Non Medi-Cal capital expenses. This amount is derived by multiplying the Total Capital Expenses amount in Column 1 by the percentage of the non Medi-Cal share of the approved budget.

Enter the Medi-Cal amount for capital expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for Capital Expenses.

Enter the Capital Expenses amount from Column 3 into Column 5, nonenhanced.

4. (IV) Total Indirect Expenses

Enter in Column 1, the total of all Indirect Expenses.

Enter the amount of non Medi-Cal indirect expenses in Column 2. This amount is derived by multiplying the total indirect expenses amount in Column 1 by the percentage of the non Medi-Cal share of the approved budget.

Enter the Medi-Cal amount for indirect expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for the indirect expenses.

Enter the indirect expenses amount from Column 3 in Column 5, non enhanced.

5. (V) Total Other Expenses

Enter the total of all other expenses on this line in Column 1.

Enter in Column 2, the non Medi-Cal other expenses. This amount is derived by multiplying the total Other Expenses amount in Column 1 by the percentage of the non Medi-Cal share of the approved budget.

Enter the Medi-Cal amount claimed for other expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount in Column 1 for Other Expenses.

Enter the amount claimed for Other Expenses from Column 3 into Column 5, nonenhanced.

6. Expenditure Grand Total

Add the totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses for each column, and enter the amounts on this line.

B. Source of Funds

1. State

Enter the amount for State in Column 2. This amount is the same as the Expenditure Grand Total amount for TOTAL CHDP Non Medi-Cal.

2. Medi-Cal Funds

The Medi-Cal Funds under the Source of Funds are calculated beginning with Column 4, Enhanced State/Federal and Column 5, State/Federal.

a. Enhanced State/Federal

Multiply the Expenditure Grand Total line of Column 4, Enhanced by 25 percent and enter this amount on the State Funds line in Column 4.

Subtract the amount of State Funds for Column 4, Enhanced from the Expenditure Grand Total line of Column 4 and enter this amount on the Federal Funds line in Column 4.

b. Nonehnanced State/Federal

Multiply the Expenditure Grand Total line of Column 5, Nonenhanced by 50 percent and enter this amount on the State Funds line for Column 5.

Subtract the amount of State Funds for Column 5, Nonenhanced from the Expenditure Grand Total line of Column 5 and enter this amount on the Federal Funds line in Column 5.

c. Total Medi-Cal Funds

Enter in Column 3 on the State Funds line the total of Column 4 and Column 5, State Funds.

Enter in Column 3 on the Federal (Title XIX) Funds line the total of Column 4 and Column 5, Federal (Title XIX) Funds.

3. Total Funds

Enter in Column 1, Total Funds for the State Funds (non Medi-Cal) line, the same amount as entered in Column 2, Total CHDP Funds.

Add Columns 4 and 5 together for the State Funds line under Medi-Cal Funds and enter the total in Column 3, total Medi-Cal and Column 1, Total Funds.

Add Columns 4 and 5 together for the Federal (Title XIX) Funds line and enter the total in Column 3, Total Medi-Cal Funds, and Column 1, Total Funds.

NOTE: The totals of funding amounts entered under each column in the "Source of Funds" section must agree with the totals for the same column entered on the "Expenditure Grand Total" line.

C. Certification and Signatures

Provide a contact name and telephone number for county or city staff responsible for compiling the expenditure invoice.

Certify the accuracy and policy compliance of the reported expenditures by signing and dating the completed invoice form.

II. Instructions for Preparation of the CHDP Quarterly Administrative Expenditure Invoice Form (County/City Match)

The county/city match invoice for expanded services for Medi-Cal recipients is 100 percent county/city funds with federal fund match. No State Funds are included on this invoice.

A. Category/Line Item

1. (I) Total Personnel Expenses

Enter the total amount of "Personnel Expenses" for the quarter being claimed on this line in Column 1. This amount is the total amount for all employees performing activities for the program as supported by time

study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

Enter the total amount of personnel expenses invoiced in Column 2 for enhanced funding and the total amount invoiced in Column 3 for nonenhanced funding. These amounts are calculated using time study percentages and other applicable documentation.

2. (II) Total Operating Expenses

Enter in Column 1, the total of all operating expenses.

Enter the total amount of enhanced operating expenses claimed in Column 2 and enter the nonenhanced operating expenses claimed in Column 3.

NOTE: Only travel and training expenses may qualify as operating expenses for enhanced funding, and only when claimed by an SPMP following specific FFP guidelines (See Section 9).

3. (III) Total Capital Expenses

Enter the total Capital Expenses on this line in Column 1 and Column 3. The definitions of equipment and prerequisites for reimbursement are found on Page 8-34.

4. (IV) Total Indirect Expenses

Enter the total Indirect Expenses on this line in Column 1 and Column 3.

5. (V) Total Other Expenses

Enter the total other expenses on this line in Column 1 and Column 3.

6. Expenditure Grand Total

Add the totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses for each column, and enter the amounts on this line.

B. Source of Funds.

1. County/City Funds

County/city expenditures must meet the Federal Title XIX funding match requirements to obtain this reimbursement but county/city matching funds are not reimbursed. Therefore, a county/city fund line is not completed on the invoice form.

2. Federal (Title XIX) Funds

a. Enhanced Funds

Multiply the Enhanced "Expenditure Grand Total" amount (Column 2) by 75 percent. Enter the amount on the "Federal (Title XIX) Funds" line, Enhanced, in the "Source of Funds" section.

b. Nonenhanced Funds

Multiply the Nonenhanced "Expenditure Grand Total" amount (Column 3) by 50 percent. Enter this amount on the "Federal (Title XIX) Funds" line, Nonenhanced, in "Source of Funds" section.

c. Total Funds

Add Columns 2 and 3 together for the Federal (Title XIX) Funds line and enter the total in Column 1, Total Funds.

C. Certification and Signatures

Provide the contact name and telephone number of the county/city staff who is responsible for processing the expenditure invoice.

The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice. An original signature is required (signature stamps are not acceptable).

Type or print the name and title of the official who signed the invoice.

State of California - Health & Human Services Agency
_____COUNTY/CITY

Department of Health Services - Children's Medical Services
QUARTER ENDING: _____
MONTH/DATE/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE
(No County / City Match)
FISCAL YEAR_____

CATEGORY/LINE ITEM	**TOTAL EXPENDITURES (COLUMNS 2 + 3)**	**TOTAL CHDP *Non Medi-Cal***	**TOTAL MEDI-CAL (COLUMNS 4 + 5)**	**ENHANCED STATE/FEDERAL 25/75**	**NONENHANCED STATE/FEDERAL 50/50**
COLUMN	**1**	**2**	**3**	**4**	**5**
I. TOTAL PERSONNEL EXPENSES					
II. TOTAL OPERATING EXPENSES					
III. TOTAL CAPITAL EXPENSES					
IV. TOTAL INDIRECT EXPENSES					
V. TOTAL OTHER EXPENSES					
EXPENDITURE GRAND TOTAL					

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL	NONENHANCED STATE/FEDERAL
COLUMN	1	2	3	4	5
STATE GENERAL FUNDS					
MEDI-CAL FUNDS:					
STATE					
FEDERAL (TITLE XIX)					

Prepared By _____ Date _____ Telephone Number _____

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

CHDP Director/Deputy Director _____ Date _____

Revision Date: November 2003

State of California - Health & Human Services Agency
_____COUNTY/CITY

Department of Health Services - Children's Medical Services
QUARTER ENDING: _____
MONTH/DATE/YEAR

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE
(County / City Match)
FISCAL YEAR_____

CATEGORY/LINE ITEM	**TOTAL EXPENDITURES (COLUMNS 2 + 3)**	**ENHANCED COUNTY/FEDERAL 25/75**	**NONENHANCED COUNTY/FEDERAL 50/50**
COLUMN	**1**	**2**	**3**
I. TOTAL PERSONNEL EXPENSES			
II. TOTAL OPERATING EXPENSES			
III. TOTAL CAPITAL EXPENSES			
IV. TOTAL INDIRECT EXPENSES			
V. TOTAL OTHER EXPENSES			
EXPENDITURE GRAND TOTAL			

SOURCE OF FUNDS	TOTAL FUNDS	ENHANCED COUNTY/FEDERAL	NONENHANCED COUNTY/FEDERAL
COLUMN	1	2	3
FEDERAL (TITLE XIX)			

_____ _____
Prepared By Date Telephone Number

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

_____ _____
CHDP Director/Deputy Director Date

Revision Date: November 2003

HCPCFC Quarterly Administrative Expenditure Invoice Instructions

In order to receive reimbursement for Health Care Program for Children in Foster Care (HCPCFC) expenditures, the Quarterly HCPCFC Administrative Expenditure Invoice must be prepared in accordance with the following instructions. The HCPCFC Quarterly Administrative Expenditure Invoice form is found on Page 8-15.

The HCPCFC Quarterly Administrative Expenditure Invoice (No County/City Match) instructions provide information and directions for the completion of the Category/Line Item, Source of Funds, and Certification and Signature sections of the invoice form. Local county and city Child Health and Disability Prevention (CHDP) programs administering the HCPCFC are reimbursed for the actual administrative costs according to the amount of State General Funds and Federal Funds (Title XIX) on the invoice form. General information about Children's Medical Services Quarterly Administrative invoices is on Page 8-1, Plan and Fiscal Guidelines Manual.

A. Category/Line Item

1. Total Personnel Expenses (see I. Total Personnel Expenses on the invoice form).

   Enter the total amount of Personnel Expenses for the quarter in Column 1. This is the total expenditure for all employees performing program activities as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, and overtime.

   Enter the total amount of state and federal funds at the enhanced percentage in Column 2.

   Enter the total amount of state and federal funds at the non-enhanced percentage in Column 3.

   The amount of enhanced and non-enhanced percentages is calculated using completed time study documents and other applicable documentation.

   The Total invoiced amount in Column 1 is the sum of the amounts in Columns 2 and 3.

2. Total Operating Expenses (see II. Total Operating Expenses on the Invoice form)

   Enter the total amount of state and federal funds for the quarter in Column 1.

   Enter the total amount of enhanced travel and training expenses in Column 2.

   Enter the non-enhanced travel and training expenses in Column 3.

   The Total Invoiced amount in Column 1 is the sum of the amounts in Columns 2 and 3.

NOTE: Only travel and training expenses may qualify in the enhanced funding category, and only when claimed for Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. Total Capital Expenses (see the shaded area III. Total Capital Expense on the Invoice form.)

   Total Capital Expenses are not allowed on the HCPCFC Administrative Budget.

4. Total Indirect Expenses (see IV. Total Indirect Expenses on the Invoice form).

   Indirect expenses are non-enhanced, they may not be claimed at the enhanced rate.

   Enter the total of internal indirect expenses for the quarter in Columns 1 and 3.

   The total Invoiced amount in Column 1 is the same as the amount in Column 3.

5. Total Other Expenses (see the shaded area V. Total Other Expenses on the Invoice form).

   Total other expenses are not allowed on the HCPCFC Administrative Budget

6. Expenditure Grand Total (see Expenditure Grand Total on the Invoice form).

   Enter the sum of the Total Personnel Expenses, Operating Expenses, and Indirect Expenses in Column 1 in the Expenditure Grand Total at the bottom of Column 1 on the invoice form.

B. Source of Funds

1. State

   Enter the amount of State General Funds expended for this quarter in Column 1.

   The Total State General Funds in Column 1 is the sum of the amounts in Columns 2 and 3.

2. Federal

   Enter the amount of Federal Funds (Title XIX) expended for this quarter in Column 1.

   The Total Federal Funds (Title XIX) is the sum of the amounts in Columns 2 and 3.

   a. Enhanced State/Federal (Column 2, Source of Funds)

      Multiply the Expenditure Grand Total line of Column 2, by 25 percent. Enter this amount in the State Funds line of Column 2.

Subtract the amount of State Funds in Column 2, from the Expenditure Grand Total line of Column 2. Enter this amount in the Federal Funds (Title XIX) line in Column 2.

b. Non-enhanced State/Federal (Column 3, Source of Funds)

Multiply the Expenditure Grand Total line of Column 3 by 50 percent. Enter this amount in the State Funds line of Column 3.

Subtract the amount of State Funds in Column 3, from the Expenditure Grand Total line of Column 3. Enter this amount in the Federal Funds (Title XIX) line in Column 3.

c. Expenditure Grand Total (Column 1, Source of Funds)

Enter in Column 1 the total of Column 2 and Column 3, in the County/City Funds line.

Enter in Column 1 the total of Column 2 and Column 3, in the Federal Funds (Title XIX) line.

NOTE: The totals of funding amount entered under each column in the "Source of Funds" section must agree with the totals for the same column entered on the Expenditure Grand Total line.

C. Certification and Signatures

Enter the name and telephone number of the staff person responsible for preparing the HCPCFC Quarterly Administrative Expenditure Invoice form.

The county/city official with the authority to certify the invoice on behalf of the county/city does so by signing and dating the completed invoice.

NOTE: An original signature is required. Signature Stamps are not acceptable.

Quarter ending: _____

month/date/year

HCPCFC Quarterly Administrative Expenditure Invoice

Fiscal Year _____

County/City Name: _____

Column	1	2	3
Category/Line Item	**Total Invoiced (2 + 3)**	**Enhanced State/Federal (25/75)**	**Nonenhanced State/Federal (50/50)**
I. Total Personnel Expenses			
II. Total Operating Expenses			
III. Total Capital Expenses			
IV. Total Indirect Expenses			
V. Total Other Expenses			
Expenditure Grand Total	$0	$0	$0

Column	1	2	3
Source of Funds	**Total Funds Invoiced**	**Enhanced State/Federal (25/75)**	**Nonenhanced State/Federal (50/50)**
State Funds	$0	$0	$0
Federal Funds (Title XIX)	$0	$0	$0
Expenditure Grand Total	$0	$0	$0

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By	Date	Phone Number
CHDP Director or Deputy Director (Signature)	Date	Phone Number

Instructions for Preparation of Child Health and Disability Prevention (CHDP) Program Foster Care Quarterly Administrative Expenditure Invoice

In order to receive reimbursement for the CHDP Program Foster Care expenditure, the Quarterly Foster Care Administrative Expenditure Invoice must be prepared in accordance with the following instructions. The Foster Care Quarterly Administrative Expenditure Invoice form is on Page 8-20.

The CHDP Foster Care Quarterly Administrative Expenditure Invoice (County/City Match) Instructions provide information and directions for the completion of the Category/Line Item, Source of Funds, and Certification and Signature sections of the Invoice form. Local county and city CHDP Programs administering the CHDP Foster Care Administrative Budget (County/City Match) are reimbursed for the actual administrative costs according to the amount of County/City Funds and Federal Funds (Title XIX) on the Invoice form. General information about Children's Medical Services Quarterly Administrative Invoices is on Page 8-1, Plan and Fiscal Guidelines Manual.

The CHDP Foster Care Administrative Budget (County/City Match) is an optional budget to fund staff working in support of children and youth in out-of-home placement or foster care. Local county/city funds may be matched with Federal Funds (Title XIX) for this budget. No State General Funds are used in this budget or included on the CHDP Foster Care Administrative Expenditure Invoice form.

A. Category/Line Item

1. Total Personnel Expenses (see I. Total Personnel Expenses on the Invoice form).

   Enter the total amount of Personnel Expenses for the quarter in Column 1. This amount is the total amount for all employees performing program activities as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, and overtime.

   Enter the total amount of county/city and federal funds at the enhanced percentage in Column 2.

   Enter the total amount of county/city and federal funds at the non-enhanced percentage in Column 3.

   The amount of enhanced and non-enhanced percentages is calculated using completed time study documents and other application documentation.

2. Total Operating Expenses (see II. Total Operating Expenses on the Invoice form).

   Enter the total amount of operating expenses for the quarter in Column 1.

   Enter the total amount of enhanced operating expenses in Column 2.

Enter the non-enhanced operating expenses in Column 3.

NOTE: Only travel and training expenses may qualify as operating expense for enhanced funding, and only when claimed by a Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. Total Capital Expenses (see III. Total Capital Expenses on the Invoice form).

Enter the total amount capital expenses for the quarter on this line in Column 1 and Column 3. The definitions of equipment and prerequisites for reimbursement are found on Page 8-34, Plan and Fiscal Guidelines.

4. Total Indirect Expenses (see IV. Total Indirect Expenses on the Invoice form).

Enter the total amount of indirect expenses for the quarter on this line in Column 1 and Column 3.

5. Total Other Expenses (see V. Total Other Expenses on the Invoice form).

Enter the total other expenses on this line in Column 1 and Column 3.

6. Expenditure Grand Total

Enter the sum of the Total Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses and Other Expenses in Column 1 in the Expenditure Grand Total at the bottom of Column 1 on the Invoice form.

B. Source of Funds

1. County/City Funds

County/city expenditures must meet the Federal Funds (Title XIX) funding match requirements to obtain this reimbursement. The county/city matching funds are not reimbursed but must be shown on the invoice.

2. Federal Funds (Title XIX)

a. Enhanced Funds

Multiply the Enhanced Expenditure Grand Total amount (Column 2) by 75 percent. Enter the amount on the Federal Funds (Title XIX) line, Enhanced, in the Source of Funds section.

b. Non enhanced Funds

Multiply the non-enhanced Expenditure Grand Total amount, Column 3, by 50 percent. Enter this amount on the Federal Funds (Title XIX) line, Non-enhanced in Source of Funds section.

c. Total Funds

Add Columns 2 and 3 together for the Federal Funds (Title XIX) line and enter the total in Column 1, Total Funds.

C. Certification and Signatures

Enter the name and telephone number of the staff person responsible for preparing the Foster Care Administrative Expenditure Invoice form.

The county/city official with the authority to certify the invoice on behalf of the county/city does so by signing and dating the completed invoice.

NOTE: An original signature is required. Signature stamps are not acceptable.

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Quarter ending: _____
month/date/year

CHDP Foster Care Quarterly Administrative Expenditure Invoice

Fiscal Year _____

County/City Name: _____

Column	1	2	3
Category/Line Item	**Total Invoiced (2 + 3)**	**Enhanced State/Federal (25/75)**	**Nonenhanced State/Federal (50/50)**
I. Total Personnel Expenses			
II. Total Operating Expenses			
III. Total Capital Expenses			
IV. Total Indirect Expenses			
V. Total Other Expenses			
Expenditure Grand Total	$0	$0	$0

Column	1	2	3
Source of Funds	**Total Funds Invoiced**	**Enhanced State/Federal (25/75)**	**Nonenhanced State/Federal (50/50)**
County-City Funds	$0	$0	$0
Federal Funds (Title XIX)	$0	$0	$0
Expenditure Grand Total	$0	$0	$0

Source City-County Funds:

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed hav e been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By	Date	Phone Number
CHDP Director or Deputy Director (Signature)	Date	Phone Number

CCS Quarterly Administrative Expenditure Invoice Instructions

The CCS Quarterly Administrative Expenditure Invoice form is found on Page 8-27.

All invoices for claiming administrative costs for the CCS Program must be prepared in accordance with the following guidelines:

I. Instructions for preparation of the CCS Quarterly Administrative Expenditure Invoice

CCS County programs are reimbursed for the State/Federal share of actual administrative costs according to the ratio of Medi-Cal caseload to non Medi-Cal caseload and based on the actual average caseload for the quarter and potential cases pending during the quarter.

An exception to the application of the ratio of caseload occurs when the expenses claimed is specific to either Medi-Cal or non Medi-Cal as in the case of Maintenance and Transportation.

The actual average caseload is defined as the count of all CCS Non Medi-Cal and Medi-Cal cases that are open (active) during the quarter, including those cases opened to the Medical Therapy Program.

A. Caseload Procedures for Reporting Caseload

1. Determine the average number of open (active) cases by adding the total number of open (active) cases recorded at the **beginning** of the quarter to the total number of open (active) cases recorded at the **end** of the quarter and dividing the sum of these by two. Enter this amount as the Total County Open (Active) Caseload.

2. Calculate the total average number of Non Medi-Cal open (active) cases by adding the total number of open (active) Non-Medi-Cal cases recorded at the beginning of the quarter to the total number of open (active) Non Medi-Cal cases recorded at the end of the quarter and dividing the sum of these by two. Enter the amount in the appropriate caseload data box.

   Calculate the corresponding percentage by dividing the total average number of open (active) Non Medi-Cal cases by the Total County Open (Active) Caseload. Enter the amount in the appropriate caseload data box.

3. Calculate the total average number of Medi-Cal open (active) cases by subtracting the total average number of open (active) Non Medi-Cal cases from the Total County Open (Active) Caseload. Enter the amount in the appropriate caseload data box.

Calculate the corresponding percentage cases by subtracting the percentage of open (active) Non-Medi-Cal cases from 100 percent. Enter in the appropriate caseload data box.

4. Calculate the Potential cases by using the same method used in determining this caseload in the approved budget.

5. Enter the Caseload Total. This is the sum of the Total County Open (active) Cases and Total Potential Cases.

B. Category Line/Item

1. (I) Total Personnel Expenses

Enter the total amount for "Personnel Expenses" for the quarter being claimed on this line in Column 1. This amount is the total amount for all employees performing activities for the program as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

Enter the total of non Medi-Cal personnel services invoiced in Column 2. This number is derived by multiplying the total expenditures for personnel services in Column 1 by the non Medi-Cal percentage of caseload.

Enter the total amount of personnel services expenditures claimed for reimbursement from Medi-Cal in Column 3. This number is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for personnel expenses.

Enter the total amount of personnel expenses claimed for reimbursement from Medi-Cal in Column 4 for enhanced funding and the total amount claimed in Column 5 for nonenhanced funding. These amounts are calculated using time study percentages and other applicable documentation.

2. (II) Operating Expenses

Enter in Column 1, the total of all operating expenses.

Enter the total of non Medi-Cal operating expenses in Column 2. This amount is derived by multiplying the Total Operating Expenses in Column 1 by the non Medi-Cal percentage.

Calculate the total amount available for Medi-Cal reimbursement of operating expenses. This amount is derived by subtracting the non Medi-Cal portion of operating expenses in Column 2 from the total Operating Expenses in Column 1.

Enter the total amount of enhanced operating expenses in Column 4 and enter the nonenhanced operating expenses in Column 5.

NOTE: Only travel and training expenses may qualify as operating expenses in the enhanced funding category, and only when claimed for Skilled Professional Medical Personnel (SPCP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. (III) Total Capital Expenses

   The definitions of equipment and prerequisites for reimbursement are found on page 8-34.

   Enter the total capital expenses on this line in Column 1.

   Enter in Column 2, the non Medi-Cal capital expenses. This amount is derived by multiplying the Total Capital Expenses amount in Column 1 by the non Medi-Cal percentage.

   Enter the Medi-Cal amount for capital expenses in Column 3 and 5. This amount is derived by subtracting the amount of non Medi-Cal capital expenses in Column 2 from the amount entered in Column 1 for capital expenses.

4. (IV) Total Indirect Expenses

   Enter the total of all indirect expenses on this line in Column 1.

   Enter in Column 2, the non Medi-Cal indirect expenses. This amount is derived by multiplying the Total Indirect Expenses amount in Column 1 by the non Medi-Cal percentage.

   Enter the Medi-Cal Nonenhanced amount for indirect expenses in Column 3 and 5. This amount is derived by subtracting the non Medi-Cal indirect expenses amount in Column 2 from the indirect expenses amount in Column 1. Column 4 is zero for indirect expenses; enhanced funds may not be invoiced for indirect expenses.

5. (V) Total Other Expenses

   Enter the total of all other expenses on this line in Column 1. Make a notation of any maintenance and transportation (M&T expenses as these expenses will be based on actual expenditures for Medi-Cal and non Medi-Cal clients and therefore cannot be distributed by caseload ratios.

   Enter in Column 2, the amount for non Medi-Cal other expenses. This amount is derived by a) subtracting the M&T expenditures from the Total Other Expenses amount in Column 1, b) multiplying the remaining other expenses by the non Medi-Cal percentage, and c) adding the actual M&T expenditures for non Medi-Cal clients.

   Enter the Medi-Cal Nonenhanced amount claimed for other expenses in Column 3 and 5. This amount is derived by subtracting the non-Medi-Cal other expenses amount in Column 2 from the total other expenses

amount in Column 1. Column 4 is zero for other expenses; enhanced funds may not be invoiced for other expenses.

6. Expenditure Grand Total

Add Totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses for each column, and enter the amounts on this line.

C. Source of Funds

1. State General Funds

Multiply the Expenditure Grand Total line of Column 2 by 50 percent and enter the amount on this line.

2. County Funds

Subtract the State General Funds amount in Column 2 from the Expenditure Grand Total line and enter the amount on this line.

3. Medi-Cal Funds

a. Enhanced

Multiply the Expenditure Grand Total line of Column 4 by 25 percent and enter this amount on the State Funds line for Column 4.

Subtract the State Funds amount in Column 4 from the Expenditure Grand Total line of Column 4 and enter this amount on the Federal Funds line in Column 4.

b. Nonenhanced

Multiply the Expenditure Grand Total line of Column 5 by 50 percent and enter this amount on the State Funds line for Column 5.

Subtract the State Funds amount in Column 5 from the Expenditure Grand Total line of Column 5 and enter this amount on the Federal Funds line in Column 5.

4. Total Expenditures

State General Funds – Enter in Column 1 on the State General Funds line, the same amount calculated for Column 2.

County Funds – Enter in Column 1 on the County Funds line, the same amount calculated for column 2.

State Funds – Add Columns 4 and 5 together for the Medi-Cal State Funds line, and enter the total in Column 1 for State Funds.

Federal Funds – Add Columns 4 and 5 together for the Medi-Cal federal Funds line, and enter the total in Column 1 for Federal Funds.

NOTE: The total source of funds entries when added together for each column should equal the amount entered on the Expenditure Grand Total line for each column.

D. Certification and Sign-off

Provide the contact name and telephone number of the county staff who is responsible for processing the expenditure invoice.

The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice. An original signature is required (signature stamps are not acceptable).

Type or print the name and title of the official who signed the invoice.

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tate of California - Health & Human Services Agency
COUNTY

Department of Health Services - Children's Medical Services
QUARTER ENDING _____
Month/Day/Year

CCS CASELOAD	Number	%
MEDI-CAL		
verage of Total Open (Active) M/C Children		
otential Cases Medi-Cal		
TOTAL MEDI-CAL		
NON MEDI-CAL		
ealthy Families		
verage of Total Open (Active) HF Children		
otential Cases HF		
Total Healthy Families		
Straight CCS		
verage of Total Open (Active) Straight CCS hildren		
otential Cases Straight CCS		
Total Straight CCS		
TOTAL NON MEDI-CAL		
GRAND TOTAL		

CCS QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE

FISCAL YEAR _____

CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MEDI-CAL (50/50) COUNTY/STATE	TOTAL MEDI-CAL STATE/FEDERAL	MEDI-CAL Enhanced (25/75) STATE/FEDERAL	MEDI-CAL Non-Enhanced (50/50) STATE/FEDERAL
	1	2	3	4	5
TOTAL PERSONNEL EXPENSE					
.TOTAL OPERATING EXPENSE					
I.TOTAL CAPITAL EXPENSE					
/.TOTAL INDIRECT EXPENSE					
.TOTAL OTHER EXPENSE					
EXPENDITURE GRAND TOTAL					

OURCE OF FUNDS					
TATE FUNDS					
OUNTY FUNDS					
IEDI-CAL FUNDS:					
STATE					
FEDERAL (TITLE XIX)					

ERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the aterials, supplies, or sevices claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures cluded in this claim; that payment has not previoulsy been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

AUTHORIZED OFFICIAL _____
ONTACT PERSON (Type or Print Name) **Signature** **Date**

( )
ELEPHONE NUMBER

AUTHORIZED OFFICIAL _____
(Type or Print Name)

Revision Date: November 03

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CCS Quarterly Medical Therapy Program (MTP) Claims Preparation Invoice Instructions

The CCS Quarterly MTP Claims Preparation Invoice form is found on Page 8-32. All invoices must be prepared in accordance with these instructions in order to receive reimbursement.

I. Instructions for preparation of the CCS Quarterly MTP Claims Preparation Invoice

CCS County programs are reimbursed for expenditures incurred in the preparation of Medi-Cal and non Medi-Cal claims submitted to the DHS fiscal intermediary for MTP services provided to CCS clients at a MTU/Certified Rehabilitation Unit. Reimbursement is according to the ration of Medi-Cal caseload to non Medi-Cal caseload.

The Medi-Cal caseload ratio is applied to the expenditures and is reimbursed at 50 percent. The non Medi-Cal ratio is applied to the expenditures and is reimbursed at 100 percent.

A. Caseload Procedures for Reporting Caseload

1. Enter the total number of MTP clients for the quarter in the caseload data box located at the top left portion of the invoice.

2. Enter the number and percentage of Medi-Cal clients of the total MTP clients in the spaces provided.

3. Enter the number and percentage of non Medi-Cal clients in the appropriate spaces.

B. Category/Line Items

1. (I) Total Personnel Expenses

The amounts invoiced for all employees must be supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

Enter the actual expenditures for salaries and wages of staff invoiced in Column 1.

Enter in Column 2 the amount claimed at 100 percent State Reimbursement. This amount is derived by multiplying the amount in Column 1 by the percentage of non Medi-Cal clients.

Enter in Column 3 the amount of expenditures claimed at 50 percent county and 50 percent state. This is the difference of Column 2 subtracted from Column 1.

2. (II) Total Operating Expenses

Enter the actual expenditures for operating expenses in Column 1. **Do not invoice any travel and training costs on this invoice**.

Enter in Column 2, the amount of expenditures claimed at 100 percent State Funds. This amount is derived by multiplying the amount in Column 1 by the percentage of non Medi-Cal clients.

Enter in Column 3, the amount of expenditures claims at 50 percent county and 50 percent state. This is the difference of Column 2 subtracted from Column 1.

3. (III) Total Capital Expenses

The definitions of equipment and guidelines for reimbursement of equipment are found on page 8-34.

Enter the total Capital Expenses on this line in Column 1.

Enter in Column 2, the amount of expenditures claimed at 100 percent State Funds. This amount is derived by multiplying the amount in Column 1 by the percentage of non Medi-Cal clients.

Enter in Column 3, the amount of expenditures claimed at 50 percent county and 50 percent state. This is the difference of column 2 subtracted from Column 1.

4. (IV) Total Indirect Expenses

Enter the total of all indirect expenses on this line in Column 1.

Enter in Column 2, the amount of expenditures claimed at 100 percent State Funds. This amount is derived by multiplying the amount in Column 1 by the percentage of non Medi-Cal clients.

Enter in Column 3 the amount of expenditures claimed at 50 percent county and 50 percent state. This is the difference of Column 2 subtracted from Column 1.

5. (V) Total Other Expenses

Enter the total other Expenses on this line in Column 1.

Enter in Column 2, the amount of expenditures claimed at 100 percent State Funds. This amount is derived by multiplying the amount in Column 1 by the percentage of non Medi-Cal clients.

Enter in Column 3, the amount of expenditures claimed at 50 percent county and 50 percent state. This is the difference of column 2 subtracted from Column 1.

6. Expenditure Grand Total

Add Totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses, and enter the amount on this line.

C. Source of Funds

1. State General Funds

Enter in Column 2 on the State General Funds line, the amount from Column 2 of the Expenditure Grand Total.

Multiply the Expenditure Grand Total in Column 3 by 50 percent and enter this amount in Column 3 on the State General Funds line.

Add Columns 2 and 3 together and enter the sum in Column 1 on the State General Funds line.

2. County Funds

Subtract the State General Funds amount in Column 3 from the Expenditure Grand Total line in Column 3, and enter this amount on the County Funds line in Column 3 and Column 1.

D. Certification and Signatures

Provide the contact name and telephone number of the county staff who is responsible for processing the expenditure invoice.

The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice. An original signature is required (signature stamps are not acceptable).

Type or print the name and title of the official who signed the invoice.

tate of California - Health & Human Services Agency

Department of Health Services - Children's Medical Services

COUNTY _____

QUARTER ENDING _____
Month/Day/Year

ledical Therapy Program (MTP) CASELOAD		
	Number	%
traight CCS		
ealthy Families		
ledi-Cal		
OTAL		

CCS QUARTERLY MEDICAL THERAPY PROGRAM

CLAIMS PREPARATION EXPENDITURE INVOICE

FISCAL YEAR_____

CATEGORY/LINE ITEM	**TOTAL EXPENDITURES** 1	**Non-M/C 100% State** 2	**M/C 50%State/50%County** **3**
I. TOTAL PERSONNEL EXPENSE			
II. TOTAL OPERATING EXPENSE			
III. TOTAL CAPITAL EXPENSE			
IV. TOTAL INDIRECT EXPENSE			
V. TOTAL OTHER EXPENSE			
EXPENDITURE GRAND TOTAL			

SOURCE OF FUNDS			
State General Funds			
County Funds			

ERTIFICATION:

I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, nd in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed xclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring ıe items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment f all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, ayrolls, and other vouchers in support of this claim are on file with the county.

AUTHORIZED OFFICIAL _____

ONTACT PERSON (Type or Print Name)

Signature **Date**

( )

AUTHORIZED OFFICIAL _____

ELEPHONE NUMBER

(Type or Print Name)

Revision Date: November 2003

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Management of Equipment Purchased with State Funds

I. County/City Guidelines for Equipment

All equipment purchased with funds furnished in whole or in part by the State under the terms of this agreement shall be the property of the State and shall be subject to the following provisions.

A. The county/city shall use its own procurement process when purchasing equipment. The cost of equipment includes the purchase price plus all costs to acquire, install, and prepare equipment for its intended use. Examples of items may include computers, printers, photocopiers, etc.

B. All equipment purchased under this agreement shall be used only to conduct business related to programs funded by Children's Medical Services (CMS) Branch.

C. The county/city shall maintain and administer, in accordance with sound business practice, a program for the utilization, maintenance, repair, protection, and preservation of state property to assure its full availability and usefulness.

D. The county/city shall forward to the CMS Branch regional office with each quarterly invoice a listing of all new equipment purchased during the quarter on the form entitled Equipment Purchased with State Funds, CMSB A-1 (see page 8-36). The CMS Branch will forward identification tags to the attention of the contact person identified on the form. All equipment must have State identification tags affixed to the front left-hand corner of them.

E. Invoices for budgeted equipment purchases are to be submitted only after the equipment is received.

F. The county/city shall submit an annual inventory of state purchased equipment on the form entitled Annual Inventory of State Furnished Equipment, CMSB A-2 (see page 8-38).

G. Final disposition of all equipment shall be in accordance with instructions from the State and reported on the Property Survey Report (see Page 8-40).

H. Management of all county/city equipment purchased with State funds shall be coordinated through the CMS Administrative Consultant in accordance with the procedures described in Section II below.

II. Tagging and Disposal of State Purchased Equipment

A. Equipment subject to these procedures is defined in the State Administrative Manual (SAM), Section 8602, as all equipment with a unit cost of $5,000 or more and a life expectancy of more than four years that is used to conduct state business.

B. In response to the CMSB A-1 received from the county/city, the CMS Branch Administrative Consultant forwards state tag(s) to the county/City with an equipment identification tag transmittal letter (see Page 8-41).

C. State-purchased equipment used by counties/cities in performance of CMS program obligations must be disposed of according to DHS procedures. Disposition occurs when funding is terminated; the useful life of the equipment is expended; the equipment is determined by the State to be obsolete for purpose for which it was intended; or any other reason deemed by the State to be in its own best interest.

1. The county/city representative submits a written request to the CMS Branch Regional Administrative Consultant to dispose of equipment, or the CMS Branch Administrative Consultant notifies the county/city in writing that certain equipment is scheduled for disposition.

2. The CMS Branch Regional Administrative Consultant notifies the DHS Business Services Section, Property Unit, of the need for equipment disposition by submitting a completed Form 152, "Property Survey Report (see page 8-40).

ate of California - Health and Human Services
epartment of Health Services

Primary Care and Fami ly Health Division
Children's Medical Services Branch

CMSB A-1
EQUIPMENT PURCHASED WITH STATE FUNDS

ounty /City Name: _____

omplete Address: _____

rogram Name: _____

rogram Contact Telephone No.:_____

Fiscal Year Budgeted: _____

DHS Requester: _____

DHS Contact Person: _____

HDS Contact Telephone No: _____

DHS PROPERTY CONTROL USE ONLY STATE ID TAG NO.	Quantity	Description 1. Include Manufacturer's name, model no./type, size, and/or capacity. 2. If motor vehicle, list year, make model no., type of vehicle (van, sedan, truck, etc.) 3. If Van, include passenger capacity.	Base Cost Per Unit	DHS Order or Document No.	Date Received	Serial No. (If Motor Vehicle, List VIN No.)
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			

evised: July 2001
MSB A-1 (7/01)

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tate of California - Health and Human Services
epartment of Health Services

Primary Care and Family Health Division
Children's Medical Services Branch

CMSB A-2
ANNUAL INVENTORY OF STATE FURNISHED EQUIPMENT

County /City Name: _____

Complete Address: _____

_____

Program Name: _____

Program Contact Telephone No.:_____

Date of Report: _____

CMS Administrative Consultant_____

Consultants Address:_____

Consultant's Telephone No: _____

DHS PROPERTY CONTROL USE ONLY STATE ID TAG NO.	Quantity	Description 1. Include Manufacturer's name, model no./type, size, and/or capacity. 2. If motor vehicle, list year, make model no., type of vehicle (van, sedan, truck, etc.) 3. If Van, include passenger capacity.	Base Cost Per Unit	DHS Order or Document No.	Date Received	Serial No. (If Mo Vehicle, List VI No.)
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			

evised: July 2001
MSB A-2 (7/01)

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TATE OF CALIFORNIA

PROPERTY SURVEY REPORT

STD. 152 (REV. 9/00)

Record as of disposition date (lost, stolen or destroyed property--record as of the date such determination was made).

RETURN TO:

REPORTING DEPARTMENT/AGENCY	Attention	DOCUMENT NUMBER
Department of Health Services	Asset Management. Unit ☐ Walter Borgelt ☐ Teresa Madeira	
RETURN ADDRESS	IMS CODE	DATE
P.O. Box 997413 1501 Capitol Avenue, Suite 71.2101 MS 1404	A-22	
CITY	ZIP CODE	REPLACEMENTS: SEE PURCHASE ESTIMATE NUMER
Sacramento, California	95899-7413	

Authority is requested to dispose of the following State property:	FUND OWNED BY	CONTACT PERSON	TELEPHONE NUMBER	ATTACHED
			( )	

ITEM-DESCRIPTION, MODEL NUMBER, SERIAL NUMBER, ETC.	STATE IDENT. NO. (1)	DATE PURCHASED	ORIGINAL COST	LOCATION (CITY)	PRESENT CONDITION	DISP. CODE*	PRICE OFFERED (2)	PRICE RECEIVED (3)	RECEIPT NUMBER
1.		/ /							
2.		/ /							
3.		/ /							
4.		/ /							
5.		/ /							
6.		/ /							
7.		/ /							

(1) PROPERTY TAG NUMBER OR ◇ NUMBER FOR VEHICLE (2) DO NOT OBTAIN BIDS ON TRADE-INS. ESTIMATE PRICE OFFERED (3) AMOUNT ALLOWED IF TRADED IN OR SOLD

***DISPOSITION CODE**

1. TRADE-IN
2. SALE (INCLUDING JUNK SALE)
3. JUNK – VALUELESS GS
4. LOST** } department of general
5. STOLEN** } services
6. DESTROYED (AS BY FIRE, ETC.) } REVIEW FOR 4, 5, & 6 IS NOT REQUIRED
7. TO BE SALVAGED
8. PROPERTY REUTILIZATION--GENERAL SERVICES, SURPLUS PROPERTY

**IF LOST, STOLEN OR DESTROYED, REFER TO SAM SECTION 8643 FOR INSTRUCTIONS.

EXPLANATION-REASONS FOR PROPOSED DISPOSITION OF EACH ITEM

APPROVED BY PROPERTY SURVEY BOARD

(A minimum of two signatures is required)

The above statements regarding state property are true and correct; culpable negligence (check appropriate box) Ⓢ *was* Ⓢ *was not involved in loss, theft, or damage; the disposition proposed is better for the public interest.*

SIGNATURE	DATE SIGNED
1.	
2.	
3.	

CERTIFICATION OF DISPOSITION

The above described property was disposed of as follows: (specify if no consideration was received)

MANNER OF DISPOSAL

DISPOSAL DATE / /

SIGNATURE *(Officer Supervising Disposal of the Property)* Ⓡ

TITLE

REVIEWED BY DEPT. OF GENERAL SERVICES

FOR DGS REVIEW, SEND TO:

Department of General Services
State Agency for Surplus Property

NORTH	SOUTH
1700 National Drive Sacramento, CA 95834	701 Burning Tree Road Fullerton, CA 92633

FOR DISPOSITION OF VEHICLES AND MOBILE EQUIPMENT, SEND TO:

Department of General Services
Office of Fleet Administration

802 Q Street
Sacramento, CA 95814

SIGNATURE Ⓡ

DATE SIGNED

(DO NOT USE HALF SHEETS OR STAPLES)

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Equipment Identification Tag Transmittal Letter

Date

County/City Program
Address
City, State Zip Code

Dear _____:

EQUIPMENT IDENTIFICATION TAG TRANSMITTAL

In accordance with State requirements for equipment management, this equipment identification tag transmittal is being issued in response to your request dated _____ and detailed on the "Equipment Purchased with State Funds" form (CMSB A-1). The enclosed Department of Health Services equipment identification tag(s) is/are to be affixed by county/city staff to the equipment as follows:

ITEM DESCRIPTION	STATE ID NUMBER

All tags must be placed on the front left-hand corner of the item. Manufacturer's marks must be left intact.

If you have any questions regarding the instructions in this letter or the appropriate procedures for affixing the enclosed tag(s), please contact me at ( ) ____ - _____.

Sincerely,

--State CMS Branch Staff Name—
Administrative Consultant
Children's Medical Services Branch

Enclosure(s)

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